Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-415	A. BUILDING: _____ B. WING _____	08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL'S PLACE	2815 CASCADILLA STREET DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on August 14, 2018. The complaint was unsubstantiated (intake #NC00141686). There were deficiencies cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities	V 000	DHSR - Mental Health OCT 25 2018 Lic. & Cert. Section	8/29/18
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and	V 108	To Correct this deficiency, for First Aid and CPR was completed 8/14/2018 and a copy of the certificate placed in the employee's record. To prevent the problem from reoccurring, training will be scheduled in advance, so that the trainer's schedule will afford time to complete before the last certificate date expires.	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: A. Joyce Jones MSN/NP TITLE: Clinical Coordinator (X6) DATE: 8/29/18

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V 108	Continued From page 1 implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure the Clinical Coordinator/Director had current training in First Aid and Cardiopulmonary Resuscitation (CPR). The findings are: Review on 8/9/18 of the Clinical Coordinator/Director's personnel file revealed: -Hired date 2007. -First Aid and CPR expired 4/23/17. -There was no evidence of a current First Aid and CPR certification. During interview on 8/9/18 with the Clinical Coordinator/Director confirmed her first aid and CPR certification expired. She would schedule training.	V 108	To ensure that this does not reoccur, the clinical coordinator will monitor, but in addition employ additional calendar reminders well in advance of the expired time. Monitoring will take place monthly, it will be documented in the monthly supervision notes and action to prevent reoccurrance will be implemented two months prior to the certificate's expiration date.	
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.	V 112		

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V 112	Continued From page 2 (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to have a current treatment plan for two of three audited clients (#1 and #2). The findings are: Review on 8/9/18 of Client #1's record revealed: -Admission date of 3/19/13. -Diagnoses of Schizophrenia Disorder, Bipolar Disorder and Moderate Intellectual Disability. -There was no current treatment plan in client's record. Review on 8/9/18 of Client #2's record revealed: -Admission date of 11/6/08. -Diagnoses of Schizophrenia Disorder, Mild Intellectual Disability and Seizure Disorder. -Treatment Plan expired 7/14/18.	V 112	For the incident pertaining to client #1; record could not be located. To correct this deficiency, the file was tracked and relocated. An investigation was carried out to learn of the reasons that this occurred. A meeting and discussion was carried out to prevent the reoccurrance. In addition, it was determined that new staff-members and or volunteers will be closely supervised and educated about the importance of documentation, file placement and file tracking. In the interim, a new ~~file~~ plan was printed from the electronic files to ensure continuation of care.	

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V 112	Continued From page 3 -There was no current treatment plan in client's record. Interview on 8/14/18 with the Clinical Coordinator/Director revealed: -Clients treatment plan had been completed. -She was not able to locate the treatment plans. -She confirmed the treatment plans in the record had expired or not available.	V 112	and placed in the client's chart. When the previous chart was located, both charts were merged as one. The clinical coordinator/ QP will monitor to ensure a non-reoccurance. Monitoring will occur after the performance of tasks done by new employees or volunteers. With respect to the deficiency pertaining to client #2, to correct this deficiency a treatment plan was updated on 8/29/2018. To prevent the reoccurance clinical coordinator will schedule review meetings and implement a plan at least two months before the current plan expires. In addition, additional calendar reminders will be implemented at least two months prior	
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed	V 536		

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V 536	Continued From page 4 by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and	V 536	The measures that were taken to correct this deficiency is that the already scheduled training took place at 3:00pm the day the deficiency was sited on 8/9/18. To prevent this problem from reoccurring, In addition to the annual staff training for NCI, training will be scheduled at least two months in advance of the date the certificate expires. The clinical coordinator will monitor the records monthly. In addition, calendar reminders has been implemented. This action will be carried out at least two months before the expiration of the current Certificate	

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V 536	Continued From page 5 (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.	V 536		

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V 536	Continued From page 6 (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure the Clinical Coordinator/Director and staff #1 had current training in alternatives to restrictive interventions. The findings are: Review on 8/9/18 of the Clinical Coordinator/Director's personnel record revealed: - Hire date: 2007. - Job title: Full-time Clinical Coordinator/Director - North Carolina Interventions Part A expired on	V 536		

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V 536	Continued From page 7 7/12/18. - There was no current NCI Part A training. Review on 8/9/18 of Staff #1's personnel record revealed: - Hire date: 2007. - Job title: Full-time Direct Care - North Carolina Interventions Part A expired on 7/12/18. - There was no current NCI Part A training. Interview on 8/14/18 with the Clinical Coordinator/Director revealed: -Confirmed NCI Part A expired for her and staff #1. -Staff were scheduled for training 8/9/18 at 3:00 p.m.	V 536		

Evidence Based Protective Interventions

EBPI

EVIDENCE BASED PROTECTIVE INTERVENTIONS

Document: 201808107787

PRINTED: August 10, 2018

PARTICIPANT

This certifies that

Joyce Young

has fulfilled all the requirements for competency in

the Approved Restrictive Intervention Curriculum

EBPI INTERVENTIONS - PREVENT

SUBJECT TO ANNUAL CERTIFICATION

Sheila Stephens

PREVENT TRAINER

Richard McDonald CEO

CERTIFICATION DATE: August 9, 2018

THIS CERTIFICATE EXPIRES ONE YEAR FROM THE CERTIFICATION DATE, AT THE END OF THAT MONTH, AND CANNOT EXCEED August 30, 2019.

American Life & Health Foundation®

BE IT KNOWN THAT

Alveth Young

Has Satisfied the Requirements for Training Course In

Adult/Child/Infant CPR, Basic First Aid and AED

THIS STUDENT HAS PASSED BASIC SKILLS EVALUATION IN ACCORDANCE WITH THE CPRANDFIRSTAID.NET TERMS AND CONDITIONS

Certificate ID: 1501432308

Date Issued: August 14, 2018 Expiration date: August 14, 2020

Contact information: contact_us@cprandfirstaid.net (203) 651-1034

ALHF®

Contact_us@CPRandFirstAid.net

Instructor

Student

Online course presented by www.CPRandFirstAid.net

8/27/18

Minutes for Monthly Staff Meetings/ Trainings

QP inquired form client and his family his needs with which to develops a PCP QP developed PCP and other supporting document for clients

* QP will monitor immediately work done by volunteers + new Employees

QP met with staff for the purposes of weekly staff meetings and training.

QP inquired into any difficulties, issues, new issues, ongoing issues of the residents.

QP discussed staff concerns.

QP taught staff on pertinent issues surrounding matters of the group home and the clients affairs.

QP reviewed client's charts with staff.

QP reviewed client's MAR with staff

QP trained staff in medication administration and documentation.

QP met with staff and client together to discuss concerns and progress of the residents.

QP met with client's family and team members to discuss plans and progress for the client

QP discussed activities in which staff can participate with clients with intent to enrich client's life.

QP listened supportively to staff and gave constructive feed back

QP coordinated appointments for client.

* QP | Clinical Coordinator Reviewed Documentation and Certificate Expiration dates.

QP / MD / QP

Durate 4

Last Transmission Oct.15.2018 06:22 PM

Name : A. Joyce Young, M.D. Michael's Place Inc

Tel : 919 294 4596

Date	Time	Type	ID	Duration	Pages	Result
Oct.15	06:17PM	Send	9197158078	04:51	11	OK

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

August 16, 2018

Dr. A. Joyce Young
Clinical Coordinator/Director
114 Crossword Drive
Durham, NC 27703

Re: Annual and Complaint Survey Completed August 14, 2018
Michael's Place, Inc., 2815 Cascadilla Street, Durham, NC 27704
MHL #032-415
E-mail Address: michaels.place07@yahoo.com
Intake #NC00141686

Dear Dr. Young:

Thank you for the cooperation and courtesy extended during the annual and complaint survey completed August 14, 2018. The complaint was unsubstantiated.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- The tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is October 13, 2018.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Bryson Brown, Team Leader at 919-855-3822.

Sincerely,

Frances E. Hicks, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Rob Robinson, Director, Alliance Behavioral Health LME/MCO
Wes Knepper, Quality Management Director, Alliance Behavioral Health LME/MCO
Leza Wainwright, Director, Trillium Health Resources LME/MCO
Kim Keehn, Quality Management Director, Trillium Health Resources LME/MCO
File